HRSA Priority Area 1: Administration

Summary:

Program Direction and System Integration: During FY 03 the public health, hospital, and pre-hospital systems continue working together to develop, implement, and support statewide emergency planning efforts. The Washington Emergency Management Council's Committee on Terrorism (COT) is responsible for the development and implementation of the statewide Emergency Preparedness and Response (EPR) plan, for response to and mitigation of the effects of man-made or natural disasters. Public and private organizations at the federal, state, and local level are involved in the COT and actively participate in this statewide emergency planning effort. A regional planning process, including regional hospital plans, regional Emergency Medical Services (EMS) and trauma care plans, and regional public plans (currently in development) has identified gaps in local and regional emergency response capacity. Hospital needs have also been identified through a needs assessment conducted in FY 02. The Washington State Department of Health (DOH) PHEPR Joint Advisory Committee has targeted the hospital gaps and needs for amelioration as part of the overall Washington Emergency Preparedness plan for FY 03. The DOH Hospital Bioterrorism Preparedness Program will also continue to coordinate EPR efforts with the CDC Cooperative Agreement Focus Areas and the four Metropolitan Medical Response System (MMRS) cities in Washington state. During FY 03 DOH will also review and comment as appropriate on DHHS-furnished documents regarding the development of the National Incident Management System (NIMS).

Hospital and Pre-hospital Systems: The hospital and the pre-hospital systems in Washington state have collaborated on general disaster response initiatives for over ten years. Hospital and pre-hospital agencies are required by law to work cooperatively in designing and implementing local and regional EMS and trauma care plans and systems, which must have DOH approval. Regional EMS and trauma care councils are also required to plan for inter-regional patient care response, and EMS and trauma system response to mass casualty incidents at all levels.

EMS and trauma care regions were originally established based on patient flow patterns in Washington State. They are currently the focal point for pre-hospital and hospital trauma care service planning, implementation, and service provision statewide. Regional hospital planning has built on this existing infrastructure during FY 02.

Hospital and pre-hospital agencies in Washington are also collaborating in planning system changes supporting improved patient care at the scene, pre-hospital determination of patient facility destination, and facility requirements regarding the treatment of both emergent and trauma patients. Existing tools, including the Washington State Trauma Triage Tool (TTT), facilitate this work; MPD-approved regional Patient Care Procedures (PCPs), regional patient care protocols, and County Operating Procedures (COPs). Training for responses to mass casualty incidents is provided under contract from DOH for both hospital and pre-hospital personnel. Local emergency management personnel

are included in the planning for both the local and regional EMS/TC systems, which determines the most appropriate methods of cooperation for all aspects of the patient care response system in the state. In addition, local Mass Casualty Incident (MCI) planning conducted through local emergency management agencies regularly includes local EMS/TC council (e.g., hospital and pre-hospital) participation. Additionally, in the near term, increased emphasis will be placed on increasing participation by local public health, tribes, military and veteran's health care facilities, and other HRSA-identified partners in statewide planning and exercises.

State EPR organization: Please see section below about ongoing collaboration between DOH and other local, state and regional healthcare and health services agencies regarding statewide emergency preparedness planning. The organizational chart for the Governor's Domestic Security Infrastructure, showing the relationship of DOH, the Washington State DOH PHEPR Joint Advisory Committee, Washington State Emergency Management Committee, the Committee on Terrorism, and other state, local, and federal agencies involved in EPR planning and implementation in Washington State, is attached as Appendix (1).

As noted, all terrorism-related EPR efforts in Washington State are coordinated through the Washington State Emergency Management Council (EMC), and more specifically through its Committee on Terrorism (COT). The Governor has charged EMC and COT with: (1) developing a statewide strategy for preventing, planning, and responding to threats and acts of terrorism, and; (2) providing a forum for general coordination and the exchange of information among federal, state, and local entities.

DOH has worked closely with the COT to determine the appropriate disposition of these resources from the federal, state, and local levels. This will be integrated with the Washington State DOH Public Health Emergency Preparedness and Response plan, and will meet the program requirements for effective and coordinated implementation of the DOH Hospital Bioterrorism Preparedness Program. DOH will work with the EMC and the COT to further describe and implement the roles of public health departments, hospitals, and supporting health care systems in the development of statewide and regional incident management systems, as specified in Cross-Cutting Benchmark #1-1.

The HRSA and CDC Advisory Committees were merged into one Washington State DOH PHEPR Joint Advisory Committee (Joint Advisory Committee) in March 2003. The membership of the Joint Advisory Committee includes representatives from the entities, organizations, and disciplines specified in the Committee membership roster described in Appendix (2).

Tribes: The membership of the Joint Advisory Committee includes representatives from the Governor's Office of Indian Affairs and from federally recognized tribes within the state. Washington State has addressed the inter-system, inter-governmental, and inter-agency coordination and collaboration on disaster response through (1) state and local emergency management plans, and (2) regionally-developed and state-approved regional EMS and trauma care plans. While these plans were originally developed with an

emphasis on non-biological emergencies, they have formed the foundation for the state disaster and biological response capability. In general, these plans describe and direct the emergency response in their coverage area, and reference and incorporate existing mutual aid agreements into their response plan operational specifications. The emphasis in past disaster planning efforts has been first response capability, with less focus on the role of local, tribal, federal, and military hospitals, and migrant and community health centers in preparedness and response.

The Joint Advisory Committee is the primary means of ensuring hospitals and primary care facilities at every level, including the tribal level, are incorporated in current and ongoing planning for bioterrorism and disaster response across the state. The Committee roster (in Appendix 2) includes, among others, the Washington State Hospital Association (WSHA), Washington State Medical Association, Washington State Nurses Association, Madigan Army Medical Center, Washington State Association of Local Public Health Officers, Association of Washington State Public Hospital Districts, Washington State Association of Community and Migrant Health Centers, Harborview Medical Center, and the Washington State Office of Indian Affairs. Input and buy-in from these organizations and institutions are considered essential to both the development and implementation of hospital preparedness activities in the state. This kind of cooperation helps assure an integrated disaster response at the local, regional, tribal, and state levels.

Beyond the overall policy role described here, the members of the Joint Advisory Committee bring to the table their perspectives from participation in local and regional planning efforts with local health agencies and hospitals. DOH is expanding its outreach efforts to tribes and working to assure their participation in these local and regional efforts. Specifically:

- DOH is in the process of identifying tribal liaisons for public health emergency preparedness and response initiatives.

- New Eastern/Western Washington State program staff will work locally to ensure appropriate tribal representatives are invited to participate in training and meetings.

- Emergency Preparedness and Response Program plan information has been requested from other states in order to assess best practices for working with tribal governments. Responses from (29) states have been received to date.

- DOH staff has attended government-to-government training to better understand how to build partnerships with tribal governments.

- Please see Cross-Cutting Activities (F), Coordination with Indian Tribes.

Border States and Canada: Hospital and local public health emergency preparedness and response efforts in Washington State will continue during FY 03 to coordinate and

cooperate with border states (Idaho, Oregon, and Alaska) and internationally with British Columbia, Canada.

Representatives from the British Columbia Ministry of Health have attended the Washington State Emergency Management Council's Committee on Terrorism meetings to provide information to the Committee on Terrorism on the bioterrorism and disaster response system in British Columbia, and to establish a dialogue regarding cross-border cooperation and planning.

In addition, the DOH contract with Harborview Medical Center to establish a redundant pre-hospital-to-hospital-to-hospital communications system in Washington State includes a requirement to establish a baseline of communications information regarding bioterrorism and disaster preparedness with surrounding governments (Oregon, Idaho, Alaska, and British Columbia) as the first step in coordinating response activities with these entities. However, past experience has shown that attempts to coordinate activities between Washington State and the province of British Columbia have usually resulted in one or the other of the governments involved indicating that such cooperation should take place through the respective national systems first. Cooperation and coordination then becomes both elusive and inconclusive. Recent national and international events, however, may make such province-to-state cooperation more acceptable (with less direct federal involvement) than has been seen in the past. New direct relationships are currently being explored through Washington State DOH, the British Columbia Ministry of Health, the Washington State Committee on Terrorism and its Canadian counterpart organizations. Washington State law authorizes the governor to enter into interstate compacts. Compacts and agreements have been entered into with border states and the Dominion of Canada for traditional emergency management activities. We are exploring the ability to amend these compacts and agreements to include public health emergencies. Please also see Cross-Cutting Activities F, Border States.

Washington State DOH Hospital Bioterrorism Preparedness Coordinator (1.0 FTE): This position coordinates the DOH activities necessary to improve the capacity of Washington State's hospitals and healthcare system to respond to bioterrorist attacks as well as to other public health emergencies. The Coordinator's duties include the following:

- Direct the Washington State DOH Hospital Bioterrorism Preparedness Program;
- Coordinate the preparedness activities within the DOH-PHEPR to assist hospitals within the larger health care system to prepare for and respond to bioterrorist events or non-terrorist epidemics and outbreaks of rare diseases;
- Develop and facilitate implementation of hospital bioterrorism preparedness and response plan protocols (and with other participating healthcare entities);
- Develop statewide hospital protocol models;
- Collaborate with other states, Canada, and national organizations;
- Develop hospital partnerships and improve communications among hospitals and local health jurisdictions, local emergency management, and local EMS systems;
- Integrate planning and implementation efforts between the DOH Public Health Preparedness and Response Joint Advisory Committee, the Emergency

Management Council's Committee on Terrorism, the EMS & Trauma Care Steering Committee's Hospital Technical Advisory Committee and other collaborating entities working to improve hospital preparedness;
- Provide hospital program staff support as appropriate to the Washington State DOH Public Health Preparedness and Response Joint Advisory Committee;
- Integrate the appropriate HRSA Priority Areas and Critical Benchmarks for hospital bioterrorism response planning criteria with statewide emergency preparedness and response plan development and implementation.

The Washington State DOH Hospital Bioterrorism Preparedness Coordinator CV is attached as Appendix (3).

Washington State DOH Hospital Bioterrorism Preparedness Medical Director (.25 FTE): This position is the physician medical director of the program, providing medical consultation and guidance to the Hospital Bioterrorism Preparedness Coordinator. The medical director works collaboratively with the DOH Senior Public Health Official, and the Bioterrorism Coordinator, to:

- Provide medical consultation and guidance to the PHEPR Joint Advisory Committee in planning and implementation efforts directed to Washington State increasing hospital preparedness in:
  - Temporary credentialing of healthcare providers to provide services in hospitals during a bioterrorism event or other public health emergency;
  - Recruitment and training of healthcare practitioners;
  - Managing and mobilizing healthcare practitioners to respond to a bioterrorism event.
- Assure integration of hospitals with the National Strategic Stockpile (SNS) program;
- Assure appropriate medical content and practice in hospital bioterrorism plans, protocols, and training curricula for healthcare practitioners;
- Act as liaison with the Washington State Medical Association, the Washington State Hospital Association and other healthcare entities; and
- Work with professional organizations to promote direct integration of bioterrorism Washington State awareness objectives into medical schools, nursing education and EMS provider curricula.

The Washington State DOH Hospital Bioterrorism Preparedness Medical Director's CV is attached as Appendix (4).

FY 03 Staffing Plan for HBPP Program Functions: In addition to the Coordinator and Medical Director, additional program staff are necessary to ensure the minimum required professional expertise to effectively meet the HRSA Hospital Bioterrorism Preparedness Program requirements for FY 03, and to fully integrate hospital preparedness and response activities not only with CDC-funded public health preparedness and response activities but also with the Washington State regional and local health jurisdictions. These staff are:

- 1 Hospital Health Services Consultant 3* – 1.0 FTE

- 1 Hospital Health Services Consultant 3* – 1.0 FTE
- 3 Public Health Services Consultant 3* (.25 FTE each x 3 positions =.75 FTE)
- Management Analyst 1 (Finance)* – 1.0 FTE
- Secretary Administrative – 1.0 FTE

(*) above denotes new requested position, reflecting significant increase in HRSA program requirements and funding. Job descriptions for these positions are included as Appendix (5).

Although not formal a part of the state DOH Hospital Bioterrorism Preparedness Program, (HBPP), nor paid from HBPP funds, each DOH division (Health Services Quality Assurance, Environmental Health, Epidemiology, Health Statistics and Public Health Laboratories and Community and Family Health) has a PHEPR Division Coordinator. This person has responsibility for preparation of his or her respective division's portion of the Washington CEMP (ESF 8). They work closely with the HBPP staff to provide assistance in developing and implementing those portions of the state EPR programs that relate to the work of their DOH division and to appropriate parts of the state CEMP.

Critical Benchmark #1:

Develop and maintain a financial accounting system capable of tracking expenditures by priority area, by critical benchmark, and by funds allocated to hospitals and other health care entities.

Strategies: What overarching approach(es) will be used to undertake this activity?

As required under Washington State law, the Department of Health uses a uniform chart of accounts and procedures consistent with generally accepted accounting principles (GAAP) to record and report all department financial transactions. This system will track costs to a level that corresponds with the detail required in federal Standard Form 424A for each focus area. The financial system is updated on a daily basis to include all revenue, expenditure and journal voucher activity.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

Budgetary coding will be assigned to the HRSA grant and each of the six CDC Focus Areas and incorporated into the chart of accounts in the department's financial accounting system.

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

Executive Staff, Office of the Secretary: Rick Buell and Kay Koth.

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

Review final chart of accounts for inclusion of necessary budget coding.

HRSA Priority Area 2-A: Regional Surge Capacity for the Care of Adult and Pediatric Victims of Terrorism

Summary:

Hospital Bed Capacity: During the past year, the Washington State Department of Health (DOH) has contracted with the Washington State Hospital Association (WSHA) to provide technical assistance with hospitals, with Harborview Medical Center to provide web-based and emergency communications infrastructure development, with Dr Nancy Auer of Swedish Medical Center to provide expert medical consultation, and with Regional EMS and Trauma Care Councils (EMSTCC) to coordinate the development and implementation of regional hospital response plans. It is the responsibility of the regional EMSTC Councils to ensure collaboration with the LHJ officials in their region by ensuring integration of CDC and HRSA planning efforts. To further ensure this collaboration, the local health officers and local emergency management review all regional hospital bioterrorism response plans. To ensure final integration with the state Comprehensive Emergency Management Plan as well as revisions to ESF 8, regional hospital response plans will be reviewed and formally approved by state DOH. With guidance from DOH, the hospitals addressed the areas of critical concern outlined in the 2002 HRSA guidance. Each region developed their regional hospital plan within the framework of 500 infectious patients presenting throughout the region.

During FY 03 DOH, with assistance from WSHA, will work with each of the nine regional hospital bioterrorism response planning workgroups and regional EMSTCCs to modify and adapt their regional hospital plans to address the new priorities identified in the 2003 HRSA guidance. DOH and the Joint Advisory Committee will coordinate with regional health jurisdictions to identify potential redundancies or resolve new issues regarding guidance for regional hospital plan development. DOH and the Committee will continue to coordinate with and integrate the regional hospital preparedness plan needs assessment results with the regional public health emergency preparedness and response public health jurisdiction efforts.

In 2002 the population of Washington State Washington States was estimated at 6,041,700. Based on this estimate and the criteria of preparing for *500 infectious patients per million-population*, the state would need to prepare a response for 3,021 patients. Currently, each of the nine emergency response regions in the state has developed a

hospital preparedness plan for response to at least 500 patients. According to this planning process, the state is preparing to respond to 4,500 infectious patients. The department plans to have each emergency preparedness and response region continue preparing for an influx of 500 patients. Based on the current planning process and the official 2002 population estimates for each region, [redacted] in the state meets the current requirement. [redacted] DOH, in conjunction with the WSHA, local health jurisdictions (LHJs), and EMS/TC Council will facilitate hospital emergency response plan amendments to accommodate this increase, in conjunction with the development of the regional public health response plan during the coming year.

As each region developed its hospital preparedness and response plan during FY03, the region focused its priorities on surge capacity and response to an incident of bioterrorism. The regional planning efforts were necessarily broad and consequently are adaptable to other public health emergencies that would involve responding to chemical, radiological, and explosive incidents. DOH, local public health, and WSHA will continue to work with each of the regional hospital preparedness planning groups to evaluate the planned response to all-hazards public health emergencies and initiate upgrades and appropriate regional hospital plan changes where needed.

DOH will work with all public health and hospital planning activities to include inpatient, outpatient, critical care, and pre-hospital response. This will also include working with system partners – EMS, hospitals, community and migrant health centers, rural health centers, tribal health clinics, outpatient facilities, poison control centers, military and veterans health care facilities, and other health care provider organizations – so that the full spectrum of patient care is incorporated into the overall response to an all-hazards emergency situation.

During FY 03, DOH will continue to work with the Washington State DOH Emergency Preparedness and Response Advisory Committee to ensure that plans include the use of and coordination with facilities and organizations outside of the hospital setting for temporary patient overflow during a public health emergency. During the initial planning process, each regional hospital planning committee involved the participation of organizations such as the Red Cross, Veteran's Administration, emergency management, police, fire, and other emergency response organizations to identify and coordinate the use of external facilities for patient overflow.

WSHA, at the request of DOH, developed and distributed to all hospital planning partners a Memorandum of Understanding (MOU) to be used as necessary by hospitals within the planning area. This MOU Washington States originally designed as an intra-regional hospital facility tool and included agreements for the care, transfer, and diversion of patients as well as sharing equipment and supplies during an emergency. This MOU can be further enhanced to serve as an interregional agreement. DOH will continue to work cooperatively with bordering states and Canada to foster an

environment of mutual aid and response planning as physical and environmental conditions dictate. Also see Crosscutting, "Border States", and Section 1.

Each regional hospital planning group has considered patient flow within the region as part of surge capacity planning. Regional hospital plans, as part of the overall public health response, will be adapted to focus on the issue of rural to urban patient flow where appropriate. Each planning region will consider appropriate patient care procedures in relation to hospital location, transportation routes and availability, and geographic limitations. Urban to rural patient flow will also be considered in the event that urban facility capacity is overwhelmed.

In conjunction with WSHA, DOH will identify and coordinate priority areas in urban, rural, and frontier portions of Washington State. Areas of particular focus involve federally recognized tribal entities and community and migrant health centers. During FY03, DOH plans to work with these entities and clinics to assess their current capabilities to respond to public health emergencies, particularly involving biological agents. This assessment will determine capabilities and capacities, as well as needs for improved planning, response, and coordination with the public health and hospital systems in their respective geographic locales.

DOH plans to work with WSHA, regional public health, and the regional hospital planning groups to develop models for pre-hospital and hospital protocols, which address the general population including children, pregnant women, the elderly, people with English as a second language and other special needs groups, regarding biological, chemical, radiological, or explosive exposures and incident response by pre-hospital and hospital personnel. The following concepts are to be pursued:

- Create regional and local disaster plans that include specific protocols for medical and logistical management of bioterrorism victims including those with special needs.
- Require adequate supplies of pharmaceuticals such as antibiotics, antidotes and vaccines in dosages.
- Include specialized health care facilities in all aspects of preparation, as they may become secondary sites for managing casualties.
- Use maternal and child health phone lines, poison control centers and other public health information resources in local and regional planning efforts. Toll-free information lines can provide updates on the situation, access to emergency health services and other pertinent information. Poison control centers can be used as central clearinghouses for information on toxicology, antidotes and treatment, and decontamination procedures.
- Include medical personnel and others skilled at evaluating and treating special patient populations as state, regional, and local disaster team members. Ensure that all standards and protocols developed address the needs of such populations.
- Prepare schools, childcare centers and after-school programs to assess their populations and develop response plans including, including notifying parents, providing or arranging care for children whose parents cannot reach them, and

rendering first aid. Coordinate care with the Superintendent of Public Instruction and the Department of Social and Health Services (DSHS) as appropriate.
- Evaluate and update the protocols with the information as research and development efforts continue with respect to appropriate and safe uses, dosages and interaction of pharmaceuticals for children, pregnant women, the elderly and individuals with disabilities.
- Coordinate with DSHS to prepare nursing homes, assisted living facilities and other congregate care facilities to assess their populations and to develop appropriate response plans.

Current state and Medical Program Director-approved county EMS protocols, as well as Patient Care Procedures and County Operating Procedures, address the issue of special needs patients during patient transfers. During FY03, DOH plans to request EMS County Medical Program Directors to review and update their current county Patient Care Protocols regarding special needs patients and special needs patient transfers with a focus on incidents involving biological, chemical, radiological, and explosive terrorist acts, and to provide technical assistance to Medical Program Directors in this area.

DOH plans to coordinate with WSHA, local health jurisdictions, and emergency preparedness and response oversight committees to ensure that the needs of non-English speaking populations are addressed through education, public service announcements, and information distribution regarding pre-event, event, and post-event actions and concerns.

As part of the regional hospital planning effort, hospitals are developing methods to respond to a large influx of contaminated patients. As a part of any hospital response plan to increase capacity, excess morgue capacity is essential, particularly when dealing with highly contagious biological agents or other weapons of mass destruction. Assuring consistency with ESF 8 of the CEMP, proper human remains decontamination, isolation, and final disposition protocols will need further refinement after consultation with local medical examiners to determine regional capabilities for disposition of human remains. Proper record keeping is critical in mass mortality situations, and plans will be developed in coordination with the state's Center for Health Statistics.

Critical Benchmark #2-1:

Establish a system that allows the triage, treatment, and disposition of 500 adult and pediatric patients per 1,000,000 population (or no fewer that 500 patients per awardee jurisdiction), with acute illness or trauma requiring hospitalization from a biological, chemical, radiological, or explosive terrorist incident.

Strategies: What overarching approach(es) will be used to undertake this activity?

Issues required to be addressed:
- 500 patients per 1,000,000 population
- Surge capacity considering biological, chemical, radiological, and explosive

events
- Priority given to biological events
- Address patient flow from rural to urban areas
- Special population considerations.

Strategy to address issues will be the upgrade of approved regional hospital plans to increase and improve regional public health and hospital capacity in order to meet FY 03 planning requirements. Washington State plans to continue smallpox vaccinations to hospital and health care workers in order in insure a safe response to a possible smallpox incident. Also, Washington State will be integrating into mass vaccination plans the lessons learned from State I smallpox vaccination efforts.

Issues recommended to be addressed :
- All components of the health care system considered (critical care, inpatient, outpatient, and pre-hospital)
- Foster mutual aid among health care facilities
- Where appropriate, develop intrastate and interstate agreements
- Address patient flow from urban to rural areas
- Identification of major rural and urban priorities
- Address jurisdictions with frontier areas
- Alternate off-site surge capacity
- Translation for non-English speaking population and hearing impaired

Strategy to address issues will be the upgrade of approved regional hospital plans to increase and improve regional public health and hospital capacity in order to meet FY 03 planning requirements.

Optional issues:
- Decontamination and disposal of human remains

Strategy to address issue will include the upgrade of approved regional hospital plans to increase and improve regional public health and hospital capacity in order to meet FY 03 planning requirements.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

The following tasks are to be conducted to carry out the strategies specified above:

1. Hospitals will work with public health regions to upgrade regional hospital plan portion of regional public health plans.
2. Hospitals will increase capacity of patient care through equipment purchases and training program implementation, per FY 02 hospital assessments.
3. Capacity expansion activities will focus on biological preparedness and response in particular and all-hazards preparedness and response in general.
4. All preparedness and response activities will cover the inclusion of organizations such as the Red Cross, local schools, churches, armories, etc. in order to incorporate facilities outside of the hospital to assist in increased surge capacity.
5. Community and migrant health centers, tribal clinics, EMS services, and hospitals will coordinate preparedness and response assessment and planning activities.

6. Develop MOUs/MOAs to foster inter-jurisdictional cooperation.
7. Work with neighboring states in developing similar cooperative agreements in consultation with the governor's office.
8. Evaluate statewide issues and regional planning activities to determine areas of concern with respect to urban, rural, and frontier issues in responding to a public health emergency involving a terrorist attack.
9. Identify needs regarding rural to urban patient flow through coordination with hospital, community and tribal clinic, military and veterans facilities, and LHJ response activities.
10. Develop response activities to address special needs populations such as children, elderly, physically and mentally handicapped, hearing and visually impaired, pregnant women, and other patients with special health care needs.
11. Address increased morgue capacities and human remains decontamination within each region through equipment purchases and response planning.

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

DOH will contract and work closely with the lead LHJ in each region to facilitate these efforts, with consulting assistance from WSHA. In consultation with DOH, each lead LHJ will determine how best to develop and manage the project as the unique needs of each region dictate.

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

1. Tracking equipment purchases, training provision and other capacity-building activities by region and facility.
2. Active inclusion of new partners specified above in response planning and assessment activities, per timeline.
3. Inclusion of existing partners specified above in increased surge capacity implementation, per timeline.
4. Development and implementation of MOU/MOAs.
5. Development of cooperative agreements with other states and Canada in consultation with the governor's office.
6. Development and implementation of response activities re: special needs populations

HRSA Priority Area 2-B: Isolation Capacity

Summary:

Hospital Isolation Capacity: The protection of clinicians, other patients, staff, and the general population from exposures to biological casualties in hospitals is being addressed by the Washington State Department of Health (DOH) through identifying resource requirements and procedures needed to provide appropriate isolation. Facilities that receive biological casualties need to have the ability to triage and separate them from the general patient population so as to isolate and contain the harmful agent, while continuing to provide appropriate care. During FY04, DOH, in conjunction with the Washington State Hospital Association (WSHA) and hospitals plan to expand on current procedures in place to provide protection for hospital staff and non-infected patients.

According to hospital assessment results, seventy-four percent of the hospitals in Washington State indicated that they have negative pressure isolation room capabilities. Twenty-seven percent indicate that their negative pressure isolation room capabilities can accommodate 10 or more beds. In the upcoming year, DOH, in conjunction with local health jurisdictions and WSHA, plans to conduct a demographics-based risk assessment to determine the appropriate facilities to be targeted for capital improvements in developing and implementing mass isolation and decontamination capabilities regarding patients with or at risk for communicable diseases (bioterrorism event), while concurrently undertaking a review and possible revision of hospital licensing requirements in this area. Current Washington State hospital licensing rules require a facility to have only one room of any size with negative air pressure capability for the management of airborne diseases, and a general "decontamination area" with shower and floor drain connected to a sanitary sewage system adjacent to the facility's emergency entrance. Discussions around this issue include participation from hospitals, WSHA, local health jurisdictions and other pertinent agencies to review and evaluate the licensing rules in an effort to determine if any changes are necessary to address air-filtered quarantine units and general decontamination capabilities.

Based on the results of the needs identified in the hospital emergency preparedness assessments and regional hospital plans, and in conjunction with the demographic-based risk assessment, DOH plans to build isolation capacities throughout Washington State using a three-phase process over a three-year period. In the initial year, DOH will work with local health jurisdictions, WSHA, and regional hospital planning workgroups to identify appropriate facilities for initial expansion. A similar process will be followed over the subsequent two years.

Phase 1 (first year – 2004)

- Identify appropriate facilities using assessment and planning needs analysis.
- Begin capital improvements to accommodate a minimum of 10 patients at the first one-third of the hospitals identified as needing such capacity.
- Begin identifying facilities for the second phase of development.
- Begin identifying potential definitive isolation facilities.

Phase 2 (second year – 2005)

- Finalize the identification of phase two facilities.
- Begin capital improvements to accommodate a minimum of 10 patients in the second one-third of the hospitals identified as needing such capacity.
- Begin initial feasibility assessments and identification of facilities for the final phase of development.
- Begin building capacities at identified definitive isolation facilities.

Phase 3 (third year – 2006)

- Finalize the identification of phase three facilities.
- Begin capital improvements to accommodate a minimum of 10 patients in the final one-third of the hospitals identified as needing such capacity.
- Complete capacity improvements for definitive isolation facilities.

Critical Benchmark #2-2:

Upgrade or maintain airborne infectious disease isolation capacity to have at least one negative pressure, HEPA filtered isolation facility per awardee, to be placed in accord with the findings of the awardee's needs assessments. Such facilities must be able to support the initial evaluations and treatment of 10 adult and pediatric patients at a time having a clinical contagious syndrome suggestive of smallpox, plague, or hemorrhagic fever, prior to movement to a definitive isolation facility.

Strategies: What overarching approach(es) will be used to undertake this activity?

Required:

- Negative pressure HEPA filtered isolation capacity
- Capacity to support at least 10 adult and pediatric contagious patients
- If the option of proposed equipment purchases or capital improvements to increase isolation capacities (below) is addressed, identify which hospital(s) in the jurisdiction will be targeted for such improvements
- All capitol improvement must be related to enhanced preparedness for response to public health emergencies

Recommended:

- Inventory of all fixed and mobile hospital isolation capabilities and facility operational characteristics

Optional:

- Propose equipment purchases or capital improvements to increase isolation capacities

Tasks: What key tasks will be conducted in carrying out each identified strategy?

- Hospitals will upgrade filtration capabilities by purchasing appropriate equipment.
- Hospitals will upgrade filtration capabilities by making appropriate facility physical improvements.
- Hospitals will increase patient isolation capacity by making fixed negative pressure isolation improvements.
- Hospitals will increase patient isolation capacity by purchasing portable negative pressure isolation equipment.
- Hospital needs assessment analyses will determine the number of current fixed and mobile isolation unit capabilities.
- Hospital needs assessment analyses will assist the efforts to determine appropriate equipment types and locations for capitol improvement.

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

DOH will work closely with the lead LHJ in each region to facilitate these efforts. In consultation with DOH, each lead LHJ is to determine how best to develop and manage the project as the unique needs of each region dictate. DOH will also work with WSHA to assist in coordination and technical expertise regarding appropriate expenditure and use of funds as it relates to hospital preparedness.

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

Progress will be determined based on decisions made regarding numbers of isolation facilities to be developed and the timeframe involved in that development. Decisions regarding numbers and locations of facilities will be based on information contained in the hospital emergency preparedness assessments, regional hospital plans, regional public health plans, and in conjunction with the demographic-based risk assessment information from the bioterrorism threat assessment information.

<u>HRSA Priority Area 2-C: Health Care Personnel</u>

Summary:

A description of the process for establishing a response system that allows the immediate deployment of additional patient care personnel that would meaningfully increase hospital patient care surge capacity.

Critical Benchmark #2-3:

Establish a response system that allows the immediate deployment of 250 or more additional patient care personnel per 1,000,000 population in urban areas, and 125 or more additional patient care personnel per 1,000,000 of population in rural areas, that would meaningfully increase hospital patient care surge capacity.

Strategies: What overarching approach(es) will be used to undertake this activity?

The department and the local public health jurisdictions have gained some experience working together to identify volunteers for the smallpox vaccination initiative. Work on this critical benchmark will build upon that experience and [redacted]. The local health jurisdictions, in cooperation with their Hospital Bioterrorism Planning Region partners, will have the central roll in identifying and mobilizing volunteers when needed from previously constructed, electronically stored lists. [redacted] is the goal. This activity will also include developing procedures for assuring the identity of volunteers at the site of the emergency and for determining the legitimacy of other individuals who present themselves at the scene as volunteer clinicians.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

1. Define information content for the system including types of clinicians and the relative proportion of each type relative the target total number for the region to be included.
2. Identify security and confidentiality requirements for the system. If needed, obtain additional authority to implement security and confidentiality requirements.
3. Design system operation accommodating, if necessary, differences in capacities of smaller, rural local health jurisdictions.
4. State and local roles and responsibilities for system maintenance and operation established
5. Using basic provider contact information from the system identify volunteers and add additional specialty and provider contact information to the system.
6. Develop agreements between planning regions for mutual support if emergency need exceeds number of clinician volunteers available within the region.
7. Test system in context of planned summer 2004 emergency exercise.
8. Identify and initiate system changes determined to be needed as a result of the exercise.

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

a. Department of Health, Health Professions Quality Assurance and Information Resource Management. Local Health Jurisdictions. State Emergency Management Division, WSHA, WSMA, and other professional health care provider organizations as appropriate
b. Local Health Jurisdictions. DOH, Health Professions Quality Assurance.
c. Local Health Jurisdictions.
d. Local Health Jurisdictions. Local exercise site participants. Department EOC, ESF#8 desk.

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

a. System development completed.
b. System contains names and contact information of LHJ recruited volunteer clinicians sufficient to meet Critical Benchmark standards.
c. Exercise demonstrates ability of system to generate number and type of clinician volunteers needed.
d. System modifications to optimize performance based upon test experience recommended.

Credentialing and Supervision:

Summary:

A description of the process for developing a system that allows clinicians to practice in facilities where they do not normally work, in emergency situations.

Critical Benchmark #2-4:

Develop a system that allows the credentialing and supervision of clinicians not normally working in facilities responding to a terrorist incident.

Strategies: What overarching approach(es) will be used to undertake this activity?

This system will be developed to operate in coordination with the [redacted] to be established under Critical Benchmark #2-3. The system must address clinician qualifications to practice in Washington State some of which is already permissible under current licensing laws. The system must also address clinician

privileges to practice at the site of an emergency, supervision of volunteer clinicians. Washington State has authorities and procedures in place that provide a solid starting place for most of these issues. State Bioterrorism Hospital Preparedness Plan staff will take the lead in organizing the work convening the interest groups to work through the issues, and coordinating with the emergency management division of the military department and other stakeholders.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

1. Existing state Emergency Management statutes and many professional licensing laws contain provisions that enable clinicians who are licensed out-of-state to practice in Washington State in declared emergencies. However, means for identifying experienced volunteers should be determined in consultation with state EMD.

2. Issues of clinician liability will have to be addressed. The current EMD statute has a liability protection provision covering EMD authorized emergency volunteers but may not be funded to address a large-scale emergency response situation.

3. Supervision requirements will be assessed through a review of the practice acts governing physicians, physician assistants, advanced registered nurse practitioners, registered nurses, licensed practical nurses, pharmacists, mental health professionals, emergency medical technicians, and paramedics. Recommendations for next steps will be prepared.

4. Verification of volunteer provider credentials for those who are licensed in Washington State can be done using the state provider look-up system. The availability of comparable verification systems in neighboring states and means of accessing them will be determined.

5. Clinician privileging is the prerogative of individual hospitals. Procedures for obtaining emergency privileges from the local hospitals will be developed in consultation with the Washington State Hospital Association.

6. Discussion with third party payers including Medicaid will be undertaken through the Association of Washington State Health Plans to assess payment and reimbursement issues.

7. Once development is complete operating procedures for the system will be distributed locally through the bioterrorism planning regions

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, “HBPP FY 03 Workplan Timelines”.

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

a. DOH BHPP and HSQA, state and local EMD
b. DOH BHPP, HSQA, EMD
c. DOH BHPP, HSQA, professional licensing boards, professional associations.
d. DOH BHPP, HSQA, Local health jurisdictions
e. DOH BHPP, HSQA, Washington State Hospital Association, WSMA, and other professional health care provider organizations
f. DOH OS, BHPP, Association of Washington State Health Plans
g. DOH BHPP

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

Progress toward Washington State completion of activity will be measured by successfully meeting the timelines specified above.

HRSA Priority Area 2-D: Pharmaceutical Caches

Summary:

Development of a statewide plan to provide pharmaceutical surge capacity at the local and regional levels, including coordination with existing pharmaceutical cache resources in the state (Strategic National Stockpile and MMRS).

Critical Benchmark #2-5:

Establish local or regional systems whereby pharmacies based in hospitals or otherwise participating in the local or regional health care response plan have surge capacity to provide pertinent pharmaceuticals in response to bioterrorism or other public health emergencies.

Strategies: What overarching approach(es) will be used to undertake this activity?

The strategy in the grant year will be to involve all of the key stakeholders to work collaboratively in exploring various options for providing pharmaceutical surge capacity and developing a plan for full implementation in ensuing years. The plan will complement the Strategic National Stockpile(SNS) planning as well as the current Chempack activities.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

1. A series of meetings/workshops will be held to explore options and assess the feasibility of providing pharmaceutical surge capacity prior to receipt of the Strategic National Stockpile. Key participants will include, among others, the State Hospital Association, the State Pharmaceutical Association, the State Pharmacy Board, and representatives of each of the state's nine public health emergency preparedness regions. Workshops will focus on such topics as options for providing needed pharmaceuticals, logistical issues, contractual arrangements, inventory management, stock rotation, storage issues, costs, etc.
2. Based upon the results of the meetings/workshops, a plan will be developed and documented for implementation of this capacity. The plan will identify participants in the system and outline roles and responsibilities as well as key operational elements. The plan will be coordinated with all other local, regional and state plans for dealing with incidents of bioterrorism or other public health emergencies.

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

1. DOH staff, Pharmacy Board, State Hospital Association, State Pharmaceutical Association, nine Regional Emergency Response Coordinators. State SNS Coordinator.
2. DOH hospital bioterrorism staff and State SNS Coordinator.

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

1. Number of meetings/work sessions held.
2. Completion of implementation plan.

HRSA Priority Area 2-E: Personal Protection and Decontamination

Summary:

The state of Washington State has 91 licensed hospitals that are part of the local and regional EPR hospital plans. During FY 02 DOH allocated funds for eight complete sets (184 ensembles) of personal protective equipment (PPE) to 23 hospitals statewide. In partnership, the Committee on Terrorism Equipment Subcommittee allocated funds to purchase portable decontamination shelters for the same 23 hospitals. This immediately created a regional level of interoperability and supported the emergency preparedness

and response capacity of hospitals statewide.

The first 23 facilities were chosen by focusing on the regional threat assessments, the ODP (formerly DOJ) risk assessment, participation in the regional planning process, and strategic location within the region and state..

Washington State Department of Health (DOH) will continue the collaborative efforts begun during FY 02, while refining them fit the FY 03 CDC/HRSA and ODP grant requirements to ensure consistency with the Washington State strategy for emergency preparedness and response. In addition, the 2002/2003 regional Bioterrorism needs assessment identified that PPE, decontamination, and training were the hospital's top three areas of need in regard to emergency preparedness and response.

Any equipment purchased with funds under this priority must meet and be consistent with the standards currently in place for Washington State regarding equipment interoperability.

The Washington State PPE standard was determined by evaluating several aspects of first responder and hospital operations and based on a minimum 12 responder model. Considerations included:

- Appropriate minimum level of protection
- Level of training for staff members
- Grooming standards (for example, N-95's or tight-fitting face masks cannot be worn if the wearer has a beard)
- Physical condition of team member (i.e., N-95's and tight-fitting masks increase the stress on the cardiovascular system)

Critical Benchmark #2-6 & 2-7:

Critical Benchmark #2-6: Ensure adequate personal protective equipment (PPE) to protect 250 or more health care personnel per 1,000,000 population in urban areas, and 125 or more health care personnel per 1,000,000 population in rural areas, during a biological, chemical or radiological incident.

Critical Benchmark #2-7: Ensure that adequate portable or fixed decontamination systems exist for managing 500 adult and pediatric patients and health care workers per 1,000,000 population, who have been exposed to biological, chemical or radiological agents.

Strategies: What overarching approach(es) will be used to undertake this activity?

The primary focus of this strategy is to equip hospitals with a minimum number of PPE

ensembles and provide them with portable decontamination shelters to triage and manage patients affected by a biological, chemical, or radiological incident.

To achieve this, the following approaches will be implemented:

- Continue with the phased approach for allocations.
- Analyze and use the findings from the 2002/2003 needs assessments to focus equipment allocations and acquisitions.
- Continue to develop the training process currently in place for PPE and decontamination.
- Develop a train-the-trainer component to ensure adequate number of available trained hospital staff at each facility.

These recommendations will be accomplished by phasing in capacity over a three-year period. Each year facilities will be identified according to criteria based on regional risk, demographics and needs assessment. Funds for equipment will be allocated in each phase to approximately one-third of the 91eligible hospitals in order to provide each with the minimum level of PPE, decontamination and detection equipment.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

1. Phase I-2002 (23 hospitals received eight sets PPE from HRSA grant; the same 23 hospitals received decon systems from EMD grant,).

2. Phase II-2003 (23 hospitals receive PPE from EMD grant; 23 hospitals receive decon systems and supplementary PPE from HRSA grant).

3. Phase III-2004 (23 hospitals receive PPE from EMD grant; 23 hospitals receive decon systems from HRSA grant).

4. Phase IV-2005 (23 hospitals receive PPE from EMD grant; 23 hospitals receive decon systems from HRSA grant).

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

1. DOH, EMD, Committee on Terrorism Equipment Subcommittee
2. DOH, EMD, Committee on Terrorism Equipment Subcommittee
3. DOH, EMD, Committee on Terrorism Equipment Subcommittee
4. DOH, EMD, Committee on Terrorism Equipment Subcommittee

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

1. 23 hospitals receive PPE and decon systems
2. 23 hospitals receive PPE and decon systems
3. 23 hospitals receive decon systems
4. 22 hospitals receive decon systems

HRSA Priority Area 2-F: Mental Health

Summary:

DOH will develop and implement a plan to address the mental health and special needs of health care workers and others who are victims of a bioterrorist attack or other disaster, and to create sustainable systems to meet the ongoing information needs of special populations. Partners in this activity will include: DOH Division of Community and Family Health (including programs providing prevention services to children and families, women and other special populations), Governor's Office on Indian Affairs, Washington State Department of Social and Health Services (including offices of Aging and Adult Services, Children and Family Services, Developmental Disabilities Division, Mental Health Services, Deaf Services, Residential Care Services), Washington State Council of the Blind, state minority commissions, Washington State Human Rights Commission, Washington State Office of Public Instruction, Washington State Department of the Military (Emergency Management Division, Public Education Unit), Washington State Coalition for the Homeless, American Red Cross (local offices), and other state, regional and local entities serving special populations.

Critical Benchmark #2-8:

Critical Benchmark #2-8: Establish a system that provides for a graded range of acute psychosocial interventions and longer-term mental health services to 5,000 adult and pediatric clients and health care workers per 1,000,000 population exposed to a biological, chemical, radiological or explosive terrorist incident.

Strategies: What overarching approach(es) will be used to undertake this activity?

DOH will develop a plan to provide consultation, technical assistance and participation on workgroups and advisory committees, review and comment on relevant materials developed, and recruitment of external medical experts as needed. Services to children need to be designed to serve them in the context of their families.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

DOH will undertake the following activities to address the needs, including informational needs of non-English speaking populations, children, the elderly, pregnant women,

individuals with disabilities and their families.

1. Develop regional and local disaster plans that include specific protocols for medical and logistical management of bioterrorism victims who are within one or more of the populations described above.
2. Require adequate supplies of pharmaceuticals such as antibiotics, antidotes and vaccines in dosages appropriate for children, the elderly, pregnant women, individuals with disabilities.
3. Include pediatric health care facilities (children's hospitals, pediatricians' offices, pediatric ERs, public health clinics) in all aspects of preparation.
4. Use maternal and child health phone lines, Poison Control Centers and other public health information resources in local and regional planning efforts. Toll-free information lines provide updates on the situation, access to emergency health services, information regarding the status of children who have been relocated and other pertinent information. During FY 03 DOH will determine appropriate role of Poison Control Centers(PCC) in these areas. In collaboration with DOH, the state PCC may be used as central clearinghouses for information on toxicology, antidotes and treatment, and decontamination procedures.
5. Include obstetricians, pediatricians and others skilled at evaluating and treating pregnant women and children as state, regional and local disaster team members. Ensure that all standards and protocols reflect the needs of pregnant women, children, and individuals with disabilities and others with special needs.
6. Coordinate with the Office of the Superintendent of Public Schools to prepare schools, childcare centers and after-school programs to assess children and develop response plans including notifying parents, providing or arranging care for children whose parents cannot reach them, and rendering first aid.
7. Evaluate and update the protocols with the information as research and development efforts continue with respect to appropriate and safe uses, dosages and interaction of pharmaceuticals for children, pregnant women, the elderly and individuals with disabilities.

With WSHA and key member organizations, DOH will form a special advisory committee on mental health and crisis communication issues with matrix partners, the Community and Agency Communications Partner Matrix (CACPM). This group will work to develop emergency communication planning recommendations and strategies for the following initiatives:

- Helping staff required to respond in a crisis to cope with the psychosocial consequences of their involvement.

- Helping the general public and special populations cope with the psychosocial consequences of a crisis. This includes effectively addressing psychosocial issues in related materials, and ensuring mental health resources are available through DOH and other emergency hotlines. (In support of hotline activities, participate in the planning of related statewide initiatives such as the Access Washington State Resource Directory—the health and human services database associated with the state's 211 initiative.)

- Ensuring the psychosocial consequences of crisis are addressed in crisis and risk communication strategies.
- Identifying training opportunities for emergency system staff.
- Reviewing materials and *best practice* and making recommendations for system use, including general public materials from the American Red Cross, and staff materials from the CDC's Crisis and Risk Communication Guide. Distribute materials and recommendations throughout the emergency partner system.
- Please see Cross-Cutting Activities F, Populations with Special Needs.

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

DOH Division of Community and Family Health with technical assistance from the American Red Cross, the American Psychological Association (BT guidelines have already been developed), Washington State Poison Control Center, Washington State Psychological Association, Mental Health Division, DSHS (each Regional Support Network has an identified county mental health professional who is skilled in crisis intervention), and the Washington State Mental Health Association.

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

1. Development of regional and local protocols for management of special populations victims of bioterrorism.
2. Appropriate equipment and supplies available.
3. Evaluation feedback from pediatric health care facilities and appropriate health care professionals regarding implementation of developed protocols.
4. Inclusion of poison control center as central information clearinghouse for toxicology, antidotes, and treatments.
5. Implementation of school and childcare center plans to handle children's issues.

HRSA Priority Area 2-G: Communications and Information Technology

Summary:

This Critical Benchmark addresses both the HRSA Hospital Bioterrorism Preparedness Program and CDC Public Health communications and information technology components (Focus Area E), as well as the appropriate DHHS Cross-Cutting Benchmarks.

HRSA Critical Benchmark #2-10: Establish a secure and redundant communications system that ensures connectivity during a terrorist incident between health care facilities and state and local health departments.

Strategies: What overarching approach(es) will be used to undertake this activity?

Note: Key stakeholders for the coming grant year are defined as local and state public health agencies, hospital emergency departments and emergency management agencies. Priority stakeholders for following years are infectious disease specialists and infection control practitioners, large clinician practices, law enforcement agencies, first responders, individual clinicians and pharmacists.

1. ***Strategies:***
    1. Assure 24/7 connectivity and communications between state health department, local health agencies, emergency departments of hospitals and emergency management agencies.
    2. Assure at least three types of redundant communications capability [redacted] are in place in state health department, local health agencies and emergency departments of hospitals, and that these connect with existing emergency management communications systems.
    3. Establish Internet-based alerting mechanisms for key stakeholders.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

1a. In conjunction with Critical Benchmarks 7 and 9 develop policies for roles and responsibilities of duty officers for each key stakeholder.

1b. Develop a communication plan for development and implementation of 24/7 emergency alerting capacity in all local and state health agencies, hospital emergency departments, and emergency management agencies.

1c. For each key stakeholder organization (each local health agency, hospital emergency department, state health department, and emergency management agency) establish a 24/7 duty officer role, define a roster of individuals responsible for carrying out that role, and provide training as necessary in conjunction with Focus Area G.
Assure that organizations lacking necessary equipment for duty officer role ([redacted] are able to acquire such equipment. Technology solution needs to be appropriate for each jurisdiction.

1e. Establish a process in each key stakeholder organization for maintaining the duty officer role and for disseminating agency contact information to other key stakeholders.

1f. Proceed with implementation of Washington State Electronic Communications and Urgent

Response System (WA-SECURES), to allow automated voice and e-mail communications with key stakeholders (initially local health departments, then hospital emergency departments and emergency management agencies).

2a. Continue current program of assessing redundant communication needs for hospitals and local health agencies.

2b. Identify gaps in redundant communication needs and provide necessary technology to fill those gaps.

2c. Continue with implementation of the hospital communications technology plan.

3a. Define the types of alerts that are routinely generated and identify the following items:
- -- Type of message
- -- Current delivery format
- -- Alert level (1 – immediate, 2 – prompt, 3 – next business day)
- -- Message confirmation required
- -- Amount of information being delivered, pamphlet, one page, book, e-mail

3b. Define standard alerting mechanisms for Internet-based systems
- -- What types of information should be disseminated via Internet-based systems?
- -- What limitations on access should there be to this information?
- -- What processes should be used for posting this information to Internet sites?

3c. Review current public health, emergency response and healthcare-related Internet sites, and identify appropriate sites for dissemination of alerts and other information to key stakeholders. Decision on appropriate sites to include consideration of:
- -- Type of system
- -- System manager
- -- Access/security level (1 – confidential info, 2 – sensitive info, 3 – general release)
- -- Support plan for 24/7 coverage/maintenance of web site
- -- Use of web site by target stakeholder audience

3d. Engage existing organizations that provide Internet-based information to key stakeholders in agreements to post alerts as necessary, following defined alerting mechanisms (i.e., [redacted] others as appropriate).

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity(ies) assigned to complete each task.

1a. State and regional emergency response coordinators.

1b. DOH Washington Electronic Disease Surveillance System (WEDSS); state and regional emergency response coordinators.

1c. Local health agencies, hospitals, state DOH, Focus Area G.

1d. DOH WEDSS.

1e. Local health agencies, hospitals, state DOH.

1f. DOH WEDSS; State and Regional Emergency Response Coordinators.

2 a, b, c. DOH Emergency Response Program.

3a. State and Regional Emergency Response Coordinators.

3b. DOH WEDSS.

3c. DOH Communications Office.

Evaluation Metric: How will the agency determine overall progress toward Washington State successful completion of the overall recipient activity?

1.Percentage of local health agencies that have identified duty officer and established 24/7 coverage.

2. Percentage of local health agencies and hospitals that have received wireless communication devices.
3. Percentage of key stakeholders with access to Washington State SECURES alerting system.
4. Percentage of key stakeholders receiving alerts via identified Internet-based information systems.

HRSA Priority Area 3: Emergency Medical Services

Summary:

Optimizing EMS Preparedness and Response Capability: Washington State's EMS Office has been active in emergency response system development since the early 1970s. The use of local and regional councils has resulted in the improvement of grass roots efforts to improve response to community-perceived needs. The councils and pre-hospital agencies have always been involved in assisting hospitals with their disaster exercises as well as the coordination of disaster response efforts through mutual aid agreements.

Statutory requirements mandate hospitals, pre-hospital EMS/TC agencies, local elected officials, consumers, local law enforcement and local government agencies work cooperatively in designing and implementing local and regional EMS and trauma care plans and systems, through the DOH-approved regional EMS and trauma care plans. Tribal government has been and continues to be involved in many of the local and regional councils' planning efforts. Other participants have been fire services,

communication centers, injury prevention programs, medical program directors, physicians, helicopter services, forest service, national and state parks and more recently representatives of emergency management and local health jurisdictions. Local health jurisdictions (LHJs) have been invited to become members. Many have declined but are represented at meetings by regional PHEPR coordinators in some cases. LHJs continue to be invited to the meetings and participate as issues come up that they perceive concern them.

The above mentioned requirements also include direction to regional councils to plan for addressing inter-regional patient care responses, transport and transfer of patients to facilities outside the region and the EMS and trauma system response to mass casualty incidents at all levels. Regional EMS and trauma care councils currently perform the following activities: (1) assess and analyze regional EMS and trauma care needs; (2) identify and implement specific activities necessary to meet state-wide standards and patient care outcomes; (3) establish the number and levels of facilities to be designated as trauma facilities; (4) identify the need for and recommend the distribution and level of care of pre-hospital services, to assure adequate availability and avoid inefficient duplication of services; and (5) advise DOH on all matters relating to EMS and trauma care delivery within the region.

EMS and trauma care regions were originally established based on patient flow patterns in Washington State. They are currently the focal point for EMS and trauma care service planning, implementation, and service provision statewide. Regional hospital planning has built on this existing infrastructure through EMS/TC regional councils serving as the coordinating bodies for regional hospital bioterrorism preparedness plan development during FY 02-03. Realignment of regional EMS/TC boundaries to match the public health jurisdiction regions is a practical solution to some confusing issues that have arisen over the last year. The current plan is to change the Regional EMS and Trauma Care Regional boundaries to match the WA State Public Health, Homeland Security, and Emergency Management regional boundaries within the next two year, and no later than 7/1/05.

Hospital and pre-hospital agencies in Washington are also collaborating in planning system changes supporting improved patient care at the scene, pre-hospital determination of patient facility destination, and facility requirements regarding the treatment of both emergent and trauma patients. Existing tools including the Washington State Trauma Triage Tool (TTT) facilitate this work, MPD-approved regional Patient Care Procedures (PCPs), regional patient care protocols, and County Operating Procedures (COPs).

Training for responses to mass casualty incidents is provided under contract from DOH for both hospital and pre-hospital personnel. Local emergency management personnel are included in the planning for both the local and regional EMS/TC systems, which determines the most appropriate methods of cooperation for all aspects of the patient care response system in Washington State. In addition, local Mass Casualty Incident (MCI) planning conducted through local emergency management agencies regularly includes local EMS council (e.g., hospital and pre-hospital) participation.

The regional EMS and trauma care plans have been used in the past to identify regional activities relating to disaster management. During FY03 the Regional Councils have been actively involved in the HRSA assessments, smallpox planning and Hospital Preparedness planning and have made great strides in getting all local and regional participants to take an active role in the statewide Hospital Bioterrorism Preparedness planning effort. The increased involvement by emergency management, local health jurisdictions and hospital administration has improved the communications between and the working relationships of all involved agencies at the local and regional levels.

The Regional EMS/TC Councils plan to work cooperatively with Washington State's 502 licensed EMS and Trauma Care (EMS/TC) pre-hospital services and 82 designated hospital trauma services during FY 03 toward a goal of having a pre-hospital emergency medical and trauma care system capable of responding efficiently, appropriately, and proficiently to acts of bioterrorism, outbreaks of infectious disease, natural disasters, and other public health emergencies that may occur in Washington State. DOH and the regional councils will also work with public health jurisdictions, emergency management and Homeland Security personnel to identify the areas of potential threat and develop plans to have regional EMS response teams to provide EMS coverage for at least 500 adult and pediatric patients per 1,000,000 population per day. The Councils will explore all available options in reviewing and establishing such response.
.

Critical Benchmark #3:

Develop a mutual aid plan for upgrading and deploying EMS units in jurisdictions they do not normally cover, in response to a mass casualty incident due to terrorism. This plan must ensure the capability of providing EMS coverage for at least 500 adult and pediatric patients per 1,000,000 population per day.

Strategies: What overarching approach(es) will be used to undertake this activity?

1. Evaluate the threat levels previously identified in previous assessments in each region to identify the areas that more likely will be potential targets in each region.
2. Consider any issues identified in those assessments relating to the ability to respond to terrorist incidents.
3. Assess the existing mutual aid agreements between EMS/TC agencies for EMS response unit deployment to terrorist incidents.
4. Assess the level of training needed by personnel working with first response agencies and EMS agencies with the Office of EMS & Trauma System licenses including those services operated by Indian Tribes.
5. Assess equipment needs of first response agencies and public safety agencies with EMS&TS licenses including those operated by Indian tribes.
6. Develop a mutual aid agreement that is capable of crossing over county and

regional boundaries to allow the EMS/TC system to provide coverage for at least 500 patients per day for each 1 million in population in the state.
7. Test the mutual aid agreement.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

1. Develop a work plan to utilize the information contained in the Progress Report.
2. Survey by EMS/TC regional councils to identify current agencies participating in such a mutual aid response system.
3. Use the information identified in the assessments to ensure coordinated EMS/TC system response in each region by providing the following training.
   a. Emergency Response to Terrorism
   b. Terrorism Awareness for Emergency Responders (Internet)
4. Use the information identified in the assessments to ensure coordinated EMS/TC response in each region by procuring specialized emergency EMS/TC system response in each region by including the following terrorism incident prevention and operational equipment in HRSA and non-HRSA grants available for such purposes.
   a. Personal Protective Equipment (PPE)
      1) Chemical Resistant Gloves
      2) Chemical/Biological Protective Undergarment
      3) Inner Gloves
      4) Chemical Resistant Outer Booties
   b. CBRNE Search & Rescue Equipment
      1) Hydraulic tools; hydraulic power unit
      2) Breaking devices (including spreaders, saws and hammers)
      3) Lifting devices (including air bag systems, hydraulic rams, jacks, ropes and block and tackle)
   c. Interoperable Communications Equipment
      [redacted]
      2) [redacted]
   d. Decontamination Equipment (interoperable)
   e. Medical Supplies
   f. Limited Types of Pharmaceuticals
5. Develop a mutual aid agreement in each region and ensure that there is adequate system response coverage across regions.
6. Conduct regional bioterrorism disaster exercises to test the mutual aid plan in each Region. These will be coordinated with other ongoing public health and hospital preparedness exercises.

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

Regional EMS/TC Councils will conduct each of the assessments and work with assigned DOH Office of EMS and Trauma System staff to complete all activities for each of the tasks. Councils will collaborate with the COT to:

- Prevent duplication of equipment purchases;
- Ensure equipment interoperability; and
- Maximize use of all available federal and state funding resources.

Regional Councils and DOH staff will work to identify new funding sources, and work with regions on all other tasks associated with EMS system development.

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

The Office of EMS and Trauma System staff will coordinate the evaluation of the regional exercise of a bioterrorism incident to assess the effectiveness of the mutual aid agreement as well as the EMS/TC system response by 8/31/04.

HRSA Priority Area 4: Linkages to Public Health Departments

Summary:

A description of proposed mechanisms to build upon or put in place a coordinated system to provide seamless hospital laboratory services in response to state public health needs in efforts led by the public health departments.

HRSA Priority Area 4-A: Hospital Laboratories

During the 2003-04 Bioterrorism Grant period, the Washington State Public Health Laboratories (WAPHL) proposes to carry out the following improvements related to cross-cutting activities (biological and chemical):

1. The WAPHL will, in consultation with the CDC and other federal/state agencies, compile a region-wide inventory of all analytical laboratories through a comprehensive survey. In this survey, the WAPHL will assess the current capabilities and capacities of laboratories in the region as well as their current capabilities and needs related to "peri-" and "post-" event involvement in emergency response activities. This survey will be administered to public and private food testing laboratories, veterinary laboratories, environmental testing laboratories,

hospital/clinical laboratories (including academic health centers), regional/local public health laboratories, public health laboratories of countries that share our borders, etc. These are laboratories that could potentially play an important role in helping public health officials respond to biological and/or chemical acts of terrorism or other public health emergencies. A summary of survey data will be compiled and a database of regional laboratory capabilities will be developed. (LINK BETWEEN FOCUS AREAS A, B, C, D, E, F, G AND HRSA PRIORITY AREA #4, Cross-cutting Benchmark #3)

2. The WAPHL will, as part of the comprehensive survey mentioned above, determine what formal and informal cooperative agreements currently exist in and among laboratories (both public and private) in the region. (LINK BETWEEN FOCUS AREAS C AND D)
3. The WAPHL will consider the results of this needs assessment survey when planning and implementing enhancements to the public health infrastructure of the state. (LINK BETWEEN FOCUS AREAS C AND D)
4. The WAPHL will consider the results of this needs assessment survey when implementing new or improved cooperative agreements between laboratories in the region. (LINK BETWEEN FOCUS AREAS C AND D)
5. The WAPHL will integrate new advanced rapid identification methods approved by the LRN into the current laboratory-testing algorithm for human, environmental, animal or food specimens. (LINKS BETWEEN FOCUS AREAS B, C AND D)
6. The WAPHL, in collaboration with cooperating partners (including hospital laboratories), will conduct a simulation exercise involving at least one biological and chemical threat agent that specifically tests laboratory readiness and capability to perform specimen threat assessment, intake prioritization, testing, confirmation, and results reporting using the LRN website. (LINK BETWEEN FOCUS AREAS A, C, D AND G)
7. The WAPHL will ensure that its laboratory registration; operations, safety, and security are consistent, at a minimum, with the requirements set forth in Select Agent Regulation (42 CFR 73) and the Patriot Act of 2001. (LINK BETWEEN FOCUS AREAS C AND D)
8. The WAPHL will enhance electronic communications and WEDDS reporting to enable integration with LRN plans (Including the use of LOINC codes for the reporting of test results). (LINK BETWEEN FOCUS AREAS C, D AND E, and HRSA Priority Area #4, Cross-cutting Benchmark #4)
9. The WAPHL will work on pre-event smallpox planning and coordination to identify laboratories that have the capacity for

LRN-validated testing and reporting of Variola major, Vaccinia and Varicella through human and environmental samples. This collaboration also includes review of established smallpox emergency procedures and specimen collection supplies. (LINK BETWEEN FOCUS AREAS B AND C)

Critical Benchmark #4-1:

A regional hospital laboratory program may be implemented, that is coordinated with currently funded CDC laboratory capacity efforts, and which provides rapid and effective hospital laboratory services responding to terrorism and other public health emergencies.

Strategies: What overarching approach(es) will be used to undertake this activity?

1. Upgrade the ability of hospital laboratories to screen or perform rule-out testing for weaponizable biological, chemical or radiological materials
2. Identify and maintain a current list of hospital laboratories that have BSL3 capacity
3. Recruit and train hospital laboratory personnel who can test for these materials, safely package and handle specimens, refer when necessary to higher-level laboratories for further testing, and handle forensic specimens that might constitute criminal evidence.
4. Establish procedures for coordinating with public health laboratories to ensure a seamless screening, testing and reporting hierarchy. This system should include the ability to refer to BSL-4 federal laboratory facilities at CDC and USAMRIID.
5. Develop a system for electronic reporting of laboratory results to hospitals and clinicians that ensures rapid access to critical diagnostic information.
6. Join efforts to fund and implement a multi-grantee plan for support of regional hospital laboratories capable of assisting in a biological, chemical or radiological terrorism response.
7. Upgrade PHL infrastructure for improvement of communication with and service to hospital laboratories.
8. Plan to improve communication between hospital laboratories and other LRN members.
9. Improve communication with hospital laboratories thru development of a LIMS at the PHL in cooperation with APHL and CDC,. Implement in the WAPHL requirements established by APHL workgroup for PHL LIMS systems.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

1a. Continuation of year 1 training program to teach hospital laboratories to "Rule out or Refer" possible bioterrorism-related clinical specimens.
1b. Provide HRSA funding to support expenses associated with bioterrorism-related (biological, chemical and radiological) training. This includes training available at

the PHL.

1c. Provide HRSA funding to hospitals in support of expenses associated with hospital proficiency testing for bioterrorism

1d. Continue with year 1 plans to establish lines of communication with hospital laboratories and local veterinary hospitals/laboratories through site visits and regional meetings, broadcast faxes, newsletters and internet sites.

1e. Continue year 1 plan to develop and maintain point-of-contact information with hospital laboratories.

1f. Continue year 1 plan to provide guidance for safe laboratory practices, quality control and quality assurance, and the adequacy of staffing and training in hospital laboratories

1g.Continue year 1 plan to train hospital laboratories on the appropriate referral of test specimens by conducting workshops and educational seminars.

1h, Continue with year 1 plans to assist in providing advanced diagnostic capabilities for agents of bioterrorism to select hospital laboratories (i.e., UW diagnosis of smallpox using EM digital imaging)

1i. Provide HRSA funding to support expenses associated with completion of PHL survey of analytical laboratories (Link with Critical Capacity #8)

1j. Provide HRSA funding to purchase Class II biological safety cabinets to hospitals where needed.

2a. Collaboration with Laboratory Quality Assurance (LQA) in maintaining list (database)

2b. Ensure list (database) is complete and that it contains all necessary fields

3a. Continue year 1 plan for expansion of the training of hospital and Level B laboratories for handling forensic specimens using chain of custody.

3b. Continuation year 1 plan of training program to teach hospital laboratories to safely transport clinical specimens using current DOT and IATA regulations.

3c. Continue to develop year 1 plan to participate in simulation exercises set up with first responders, hospital laboratories, other LRN laboratories and the state EOC.

3d. Develop and distribute reference materials to be used by hospitals and Level B laboratories.

4a. Continue with year 1 plan for maintenance and upgrade of a database of hospital and Level B laboratories to monitor roles, responsibilities and capacities.

4b. Continue year 1 plan to develop in-depth wet workshops for hospital laboratories

4c. Include ability to refer to BSL-4 federal laboratory facilities at CDC and USAMRIID

4d. Maintain documentation that LRN trained hospital laboratories are willing to participate in the testing of clinical specimens associated with bioterrorism.

5a. Continue year 1 plan for hospitals to acquire equipment to communicate more effectively with hospital laboratories and other LRN members.

5b. Collaborate with LQA to expand and maintain the PHL hospital laboratory database to include current e-mail, phone and fax numbers of hospital laboratories (document that faxes are in a secure location in hospital laboratories).

5c. Ensure that the PHL database of hospital laboratories keeps and maintains the name

of a 24/7 contact at the hospital laboratory (Supervisor/Director)

6a. Continuation of year 1 plans for development of surge capacity to include other state public health labs and Level B support within the state. The proposal includes training of hospital laboratories in the implementation of surge capacity plans.
6b. Expand year 1 plan for coordination of the process of referral of blood and urine specimens to CDC, or to a CDC supported laboratory, for analysis of chemical agents. Protocols will be consistent with CDC procedures.
6c. Expand year 1 plans to coordinate with the Clinical Laboratory Advisory Council (CLAC) in the development of guidelines for managing bioterrorism events.
6d. Work with CLAC to establish a bioterrorism committee that can be used to address questions and concerns among the laboratory community.
6e. Provide HRSA funding to hospital laboratories for purchase of sample shipping containers that meet current standards (i.e., DOT and IATA).

7a. Complete year 1 plan for acquisition of a satellite downlink for WAPHL (Link to Focus Area G).

8a. Continue year 1 plan to publish *ELaborations* as a means of updating the laboratory community on BT issues.
8b. As a follow-up to year 1 plans, update and distribute a list of professional organizations and other laboratory groups in Washington State for distribution among hospital laboratories and other LRN members.
8c. Continue year 1 plan to bring together hospital laboratory practitioners, university laboratories and infectious disease physicians, as well as state and local public health laboratory practitioners in the design and execution of studies to assess and improve LRN laboratories.

9a. Allow ordering of tests using a web-based interface
9b. Allow hospitals to query the PHL LIMS for test results through a secure access.
9c. Allow electronic reporting of test results by the PHL
9d. Allow hospitals to order test kits from the PHL using a web-based interface.
9e. Allow for billing for laboratory services when appropriate
9f. Allow hospitals to request/sign-up for training on-line.
9g. Allow rapid and efficient mutual assistance (surge capacity) between reference laboratories
9h. Ensure PHL LIMS development includes adherence to national standards (e.g., LOINC)

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

1a. LPA
1b. LPA
1c. Micro OD
1d PHL Director
1e. Training Manager
1f. Training Manager
1g. LPA
1h. PHL Director
1i. Operations Manager
1j PHL Director

2a. Training Manager
2b. Training Manager

3a. LPA
3b. LPA
3c. Div ERP
3d. Training Manager

4a. Training Manager
4b. Training Manager
4c. LPA
4d. BT Coordinator

5a. LIMS Coordinator
5b. Training Manager
5c. Training Manager

6a. 8/04
6b-6d. 12/03
6e. 11/03

7a. 8/04

8a. Ongoing
8b. 12/03
8c. 8/04
9a. -9h Ongoing

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

1a. Training Schedule
1b. Travel Documents
1c. Proficiency results
1d Meeting notes, etc

1e. Point-of-contact list
1f. Guidance documentation
1g. Training schedule
1h. Purchase orders and MOU
1i. Completed survey
1j. Purchase orders

2a. Completed database
2b. Database field list

3a. Training plan
3b. Training schedule
3c. Exercise plan
3d. Reference materials

4a. Updated database
4b. Training plan
4c. Procedures
4d. Signed Documentation

5a. Purchase orders
5b. Database
5c. Updated database

6a. MOUs and consolidated contracts
6b. Process and training documentation
6c. Meeting notes and guidelines
6d. Committee minutes
6e. Purchase orders

7a. Project documentation

8a. Publications
8b. Updated list
8c. Meeting minutes

9a. Operational web interface
9b. Operational query
9c. Electronic reporting
9d. Electronic test ordering
9e. Electronic billing
9f. On-line training registration
9g. Inter-state electronic test reporting
9h.LIMS requirements document

HRSA Priority Area 4 B: Surveillance and Patient Tracking

Summary:

The purpose of this priority area is to expand both rural and urban surveillance efforts at the hospital, outpatient and pre-hospital levels, in coordination with what is being accomplished through the CDC terrorism cooperative agreement at the public health department level.

Critical Benchmark #4-2*:*

Enhance the capability of rural and urban hospitals, clinics, emergency medical services systems and poison control centers to report syndromic and diagnostic data that is suggestive of terrorism to their associated local and state health departments on a 24-hour-a-day, 7-day-a-week basis.

Strategies: What overarching approach (es) will be used to undertake this activity?

Hospitals and public health agencies will coordinate efforts to improve notifiable condition surveillance, specifically for immediately notifiable conditions and disease syndromes or clusters that may be suggestive of bioterrorism. Work described for this priority area will focus on improvement of current systems for notifiable condition reporting and developing the technology infrastructure to electronically share data between hospitals and public health agencies.

Healthcare facilities in Washington State are required to report notifiable conditions, including diseases of suspected bioterrorism origin, according to guidelines in Washington Administrative Code (WAC) 46-101. Working closely with local public health agencies and public health preparedness regions in Washington State, hospitals will document policies and procedures for notifiable condition reporting in accordance with WAC 246-101. These procedures should include specific LHJ telephone and fax numbers for notifiable condition reporting, timeframes, criteria for reporting, and staff responsible for these tasks. As these policies and procedures are being developed, the focus should rest on immediately notifiable conditions and disease syndromes or clusters that may indicate terrorism. Hospital staff identified with responsibilities for reporting should be trained on the policies and procedures by, or in conjunction with, local public health agencies. Local health jurisdictions and/or public health regions must ensure that healthcare facilities have access to appropriate resources for notifiable condition reporting, including but not limited to, notifiable conditions posters, websites, guidelines for surveillance and reporting, and newsletters or other communication mechanisms documenting the number and type of conditions reported.

Healthcare facilities will begin to develop technology infrastructure to support electronic data interchange with a variety of partners. The State Department of Health (DOH) will guide these efforts by providing standards built on the Public Health Information

Network (PHIN) and other national standards as appropriate, as well as lessons learned from existing systems which support electronic data interchange between hospitals and public health agencies (i.e., electronic laboratory-based reporting and syndromic surveillance demonstration projects). As healthcare facilities develop the capacity to generate electronic messages according to national standards, through modification of existing information systems or implementation of new systems, DOH will provide the functional requirements necessary for sending electronic messages to the public health system. These activities are consistent with ongoing work to allow clinical and hospital laboratories to electronically generate and send notifiable condition reports to public health agencies (see CDC Critical Capacity 5, Activity 12 for further description) and will initiate and inform efforts in future years to build systems for reporting notifiable conditions electronically to local and state public health agencies.

Develop a pilot, web-based, secure reporting system for health care providers that would receive both diagnostic and syndromic case reports. Identify a Local Public Health Region that will use existing NEDSS/WEDSS data security and infrastructure standards in close collaboration with the Washington State DOH WEDSS program to pilot the development of the web-based reporting system. The pilot region will consult with local hospitals and key reporters regarding web site design and content. Content of web site might include comprehensive information on surveillance for clinicians including notifiable condition reporting requirements and procedures, case definitions, laboratory testing, infection control and exposure management considerations, etc.

An electronic data interface has been established from the Washington State Poison Control Center for the purposes of providing data to the DOH Pesticide Poisoning Program. State and Regional Focus Area B Surveillance Coordinators will explore the utility of this data for syndromic surveillance indicators of potential bioterrorism or disease outbreaks.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

1. Identify current hospital staff to serve as a surveillance liaison with local public health jurisdiction concerning notifiable condition reporting and other surveillance activities; including provision of centralized email for dissemination of important public health alerts.
2. Develop policies and procedures for reporting notifiable conditions, particularly immediately notifiable conditions and syndromes or clusters that may indicate bioterrorism.
3. Ensure inclusion of expectations for making progress toward Washington State capability to generate electronic messages in standard format as part of HRSA contract with hospitals.

4a. Identify a Local Public Health Region interested in developing a pilot web-based, secure reporting system for health care providers

4b. Develop a model for authenticating providers and collecting notifiable and syndromic disease reports electronically.

4c. Develop a secure web site to host content describing notifiable conditions and reporting criteria. (e.g., what conditions are reportable, whom to report to, when to report, what to report, what specimens to submit, who to submit specimens to, etc.).
4d. Develop a strategy for maintaining access control and password information for providers to allow them to submit disease reports electronically.
4e. Develop the ability to receive reports of notifiable conditions electronically via web-based reporting.
4f. Evaluate the usefulness of the web-based system for receiving notifiable condition and syndromic reports
5a. Obtain data on a daily basis from Washington State Poison Control Center (via TransAct Washington State)
5b. Explore utility of the Washington State Poison Control Center for syndromic surveillance

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

1. Hospitals, regional surveillance coordinators and/or local communicable disease staff
2. Hospitals, regional surveillance coordinators and/or local communicable disease staff
3. WEDSS and HRSA lead
4a. Focus Area B Lead, WEDSS and HRSA lead
4b. Identified LHJ Regional Lead, WEDSS
4c. Identified LHJ Regional Lead, WEDSS, Focus Area B
4d. Identified LHJ Regional Lead, WEDSS
4e. Identified LHJ Regional Lead, WEDSS, Focus Area B, Focus Area G
4f. Identified LHJ Regional Lead, WEDSS
5a. State Surveillance Coordinator
5b. State and Regional Surveillance Coordinators

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

- Policies and procedures for notifiable condition reporting documented in at least 50% of hospitals
- HRSA Hospital Contracts include IT specification for electronic messaging
- LHJ Regional Lead identified to pilot web-based reporting system
- Web based reporting system piloted in hospitals in 1 Public Health Region

HRSA Priority Area 5: Education and Preparedness Training

NOTE: As an integral part of both the FY 03 HRSA and CDC grants, the FY 03 HRSA Education and Preparedness Training Priority Area is included within the Focus Area G (Training) section of the FY 03 CDC grant application, specified below.
Please also see Cross-Cutting Activities F, Education and Training, and Cross-Cutting Activities F, Involvement of Academic Health Centers.

Summary:

Addressing the training needs of health professionals in hospital settings will involve a number of categories of education and training activity. Strategies will include: 1) improving integration with CDC funded focus areas and other programs through the support of human resource capacity, 2) a learning needs assessment and training plan, 3) supporting smallpox response training, 4) defining a learning management system for Washington State, 5) academic collaboration and 6) learning technology improvements.

Strategy 1: Improving integration with CDC funded focus area and other programs through the support of human resource capacity:

Continue to leverage existing local, state and federal training and distance learning capacity through investments in local and state staff with expertise in technology applications, instructional design, and training/learner support at the regional and state levels.

To improve integration with each focus area and other related content areas, identify individuals within these areas and/or programs to serve as liaisons who have both content and training expertise. Some of these liaisons will require additional funding:

- Focus Area B liaison to serve as Epidemiology Learning Liaison
- Smallpox education/training coordinator/liaison with the Immunization Program
- Focus Area C/D liaison integrates with lab on HRSA ed/training activities with the hospitals
- HRSA Learning Liaison for Ed/Training activities to integrate with the hospitals
- Chemical and Radiological Liaison for ed/training activities to integrate with Environmental Health.

Tasks	Timelines	Responsible Party
State Level: Identify or include additional funding and FTE support for: ▪ Epidemiology Learning Liaison • Lab Learning Liaison • Communications Liaison • **Hospital Learning Liaison** • Chemical/Radiological Liaison (located in Environmental Health)	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	Focus Area G Coordinator/Budget Specialist Focus Area Leads/Coordinators Environmental Health Divisional Planner

Evaluation Metric:

- Liaison roles identified or hired
- Routine coordination/planning/development meetings planned and held
- Number of workforce trained
- Number of classroom training experiences provided
- Number of distance-based experiences provided

Strategy 2: Learning Needs Assessment and Training Plan

Assessment

- Using data identifying education/training priorities from the 2002 EPR LHJ and **hospital capacity assessments**, implement a qualitative assessment (using focus groups and/or other methods) to further clarify competency and performance areas to target for learning projects. Training needs assessment data will be used from all CDC focus areas including data from a needs assessment conducted through Environmental Health for chemical and radiological ed/training.
- Analyze the qualitative data to make decisions about curriculum development projects
- Review existing curriculum and learning resources, identify gaps and recommend additional products for development.

Training Plan

- Create list of learning products and services that meet the priority learning needs and address performance needs as outlined in regional EPR plans.
- Choose modes of delivery for identified list of learning products and services that fit within the technical capacity available to the priority stakeholders, based on the 2003 EPR capacity assessment. Develop strategies to deliver the most-needed learning first
- Use LMS to assess individual competency level, link available learning resources to assessment and evaluate learning products and services.
- Develop and implement evaluation tools for exercises and drills
- Incorporate chemical and radiological education/training into regional training plans
- Ensure regional hospital training plan integration with regional public health training plans.

Tasks	Timelines	Responsible Party
Assessment Review and analyze 2003 WA Public Health Standards Baseline Evaluation Study to identify performance gaps and target learning initiatives to link with learning needs identified from the LHJ and hospital EPR assessments where appropriate.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Contractor (TBD) • Focus Area G Coordinator • PHIP WFD Committee
Collaborate with each RLS to review the existing quantitative data from the capacity assessments to further define regional learning priorities. Select the appropriate qualitative methodology for	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Contractor in coordination with RLS • Focus Area G Coordinator

those areas needing additional definition. Implement the qualitative methodology to get input from representatives from each key stakeholder organization (local health agency, hospital emergency department, infectious disease specialists and emergency management agency) to further define roles and target performance areas for learning. A separate focus group will be conducted with key state public health professionals.		
Inventory, review (with SMEs-focus area/program liaisons), and catalogue existing products related to targeted performance areas for learning.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • RLS • Focus Area /Program Liaisons
Conduct chemical and radiological training needs assessment Review and analyze assessment data	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• EHP Divisional Planner • Focus Area G Coordinator • RLS • RERC's • EH Learning Liaison • Hospital Learning Liaison
Training Plan Inventory and evaluate available learning offerings that meet identified priorities. Identify gaps to design products for needs that are not met by existing offerings	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • RLS • Focus Area /Program Liaisons
Use multiple modalities to deliver learning modules	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • Distance Learning Managers

		• RLS
Develop fast-track learning for the frontline workforce on topics needing rapid and timely public health response. Monitor Health Alert Network and other sources of emerging public health concerns and issues for those topics needing rapid response Collaborate with Focus Area F to identify credible sources of information so that learning tools can be identified, developed and disseminated quickly	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • Distance Learning Managers • RLS • Focus Area/Program Learning Liaisons
Incorporate into regional training plans based upon assessment determination Update and disseminate chemical and radiological materials as required and appropriate	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• EHP Divisional Planner • Focus Area G Coordinator • RLS • RERC's • Focus Area Leads/Coordinators • Hospital Learning Liaison
As users enroll in the LMS, assess their competency level and track use of learning resources. Use evaluation results for performance improvement	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • Focus Area/Program Liaisons
Collaborate with Focus Area A Learning Liaison to develop criteria for evaluation within drills and exercises that will identify performance gaps. Use evaluation data to identify competency areas requiring additional learning strategies. Develop and implement	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • Focus Area A Learning Liaison • RLS

learning strategies to address identified areas for improvement.		

Evaluation Metric:

- Prioritized list of learning needs identified from analysis of 2002 Washington State Public Health Standards Baseline Evaluation Study, analyses of EPR assessments and regional EPR plans
- Specific performance areas targeted for learning for each region
- On-line catalogue of existing resources linked to EPR and PHIP competencies for the top 3 public health and **hospital priority areas**
- Learning Products and services that can be accessed by all end users
- A system that tracks the competency of the workforce to identify training needs as well as a system that can quickly respond to critical newly identified needs.
- Number of learning products provided
- Number of participants from each stakeholder group
- List of performance gaps identified from drills and exercises
- Learning strategies implemented to address performance gaps from drills and exercises
- Completed chemical and radiological training needs assessment
- Chemical and radiological education/training incorporated into regional training plans (with special attention to protocols and procedures training)
- Chemical and radiological education/training tracked and reported through an LMS or WAPHTN
- Distribution of updated chemical and radiological materials

Strategy 3: Supporting Smallpox Response Training

- Review lessons learned from pilot clinics and implementation of Stage 1 focusing on pre-event preparation. Disseminate to the public health agencies and **hospitals**. Revise the Washington State Smallpox Response Plan as necessary to include a pre-event component as well as post-event.
- Continue to update and disseminate materials to those at the regional level trained in 2003 as trainers and who serve in key roles as take readers, adverse events monitors, vaccinators etc.
- Provide ongoing training sessions as needed to address Stage 1 implementation needs and for Smallpox Response teams
- Upon modification of Smallpox Response plan, modify the pre-event training plan to address post-event scenarios.

Tasks	**Timelines**	**Responsible Party**

Review and evaluate after action reports from all clinics being held in the state to assess the level of competencies gained from training to determine what changes, additions, deletions, etc. need to be made to improve training materials Additional training will occur based on assessments. A plan for continuation of training for new staff added and updating of those already trained will be developed in collaboration with the 9 Regions in Washington State and other focus area leads.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	Focus Area G Coordinator Smallpox Training Liaison Focus Areas A/B Learning Liaisons RLS
Review smallpox response plans and identify protocols and procedures that are needed to guide the PHSRT. Conduct training needs assessment based on protocols and procedures Implement training as indicated by the assessment and package into a format for routine use by response team members.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	Focus Area G Coordinator Smallpox Training Liaison Focus Area B Learning Liaison RLS
Upon modification and revision of the DOH Response plan, modify pre-event Stage 1 training plan so that there is more emphasis on mass vaccination of large populations. Pre-vaccination and post-vaccination education will have to be conducted differently for a post-event. Materials or techniques will need to be adapted. Utilization of pre-existing materials will be an important technique. CDC has developed a post-event pre-vaccination patient advice video, DVD and accompanying materials that will be utilized as well. Implement mass vaccination training plan as needed	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	Focus Area G Coordinator Smallpox Training Liaison Focus Areas B/A Learning Liaisons RLS
Evaluation Metric: • Report on lessons learned from pre-event pilot clinics and subsequent regional clinics • DOH Smallpox Response Plan modified into pre and post event procedures and guidelines • Smallpox Training Plan modified according to Response Plan modifications • Distribution of updated materials • Protocols and procedures developed for Smallpox Response Teams (SRT) • Training Assessment of Smallpox Response Teams completed • Training completed for SRT		

- Package training in format for ongoing use

Strategy 4: Learning Management System (LMS)

- Define and prioritize the functional requirements (to include the ability to share best practices) for an LMS to be run by DOH and used as administrative tools by the regions and other stakeholders
- Select vendor, LMS product or enhance existing on-line registration system.
- Establish infrastructure, consistent with state Washington State standards, Public Health Information Network (PHIN) and other national standards
- Test and refine as appropriate
- Develop implementation and ongoing evaluation plan

Tasks	Timelines	Responsible Party
Educate Regional Learning Specialists (RLS's) about LMS and collaborate to define functional elements for an LMS.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • Learning Technology Specialist
Communicate, inform and educate priority stakeholders (State, regional and local public health with special attention to laboratorians, hospitals and others) about LMS and its business value as it relates to the EP/BT program.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • Learning Technology Specialist • Regional Learning Specialists • NWCPHP
Meet with vendors to review functionality requirements (including reporting capabilities), feasibility, costs and compatibility with PHIN/DOH functions, specifications and standards. Determine if several different sets of competencies can be incorporated into an LMS (e.g. DOH, PHIP, Public Health Nursing, etc.) and if they can be used in conjunction with EPR/BT competencies. Determine capabilities for "best practices" identification within LMS.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • Learning Technology Specialist • Contractor

Select web based courses to be offered through LMS.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • Learning Technology Specialist • RLS • Focus Area/ Program Liaisons • NWCPHP
Establish LMS pilot for key stakeholders. Develop full implementation and ongoing evaluation plan. Evaluate pilot of LMS making adjustments as necessary.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	• Focus Area G Coordinator • Learning Technology Specialist • Regional Learning Specialists • Key Stakeholders (**Hospitals,** NWCPHP, Focus Area/Program Liaisons)

Evaluation Metric:

- List of functional requirements for the LMS
- Contract, lease or purchase
- A functional LMS consistent with all appropriate standards
- Pilot program completed and evaluated
  DOH implementation completed for primary stakeholders
- Tracking and management of education/training occurring consistently for participating stakeholders

Strategy 5: **Academic Collaboration**

- Continue providing funding support at the current level to the Northwest Public Health Leadership Institute and market the program to the Washington State public health workforce.
- Collaborate with the UW Center for Preparedness to disseminate lessons learned from Top-off2 to key stakeholders.
- Collaborate with NWCPHP and Thurston County Health Department on Public Health Ready pilot project.
- Review and evaluate existing learning products developed by academic institutions to address priority learning needs that emerge from the EPR hospital and LHJ assessments
- Collaborate with the NWCPHP and HHS Region 10 to identify groups in the Northwest region who are looking into using web conferencing soft ware to deliver presentations.

Tasks	**Timelines**	**Responsible Party**
Provide funds to UW to support scholars attending from Washington State	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	Focus Area G Coordinator
• Participate in scheduled meetings and activities for PH Ready pilot program as required	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	Focus Area G Coordinator RLS Region 3 NWCPHP Representative
▪ Collect and synthesize available information to identify lessons learned from Top-off2. ▪ Determine the best methods for dissemination. ▪ Deliver to key stakeholders using a variety of mediums.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	Focus Area G Coordinator NWCPHP HHS Region 10
▪ In collaboration with DOH, the RLS group, develop criteria to evaluate learning products produced by academic institutions and others for use with various stakeholders. ▪ Upon determining LHJ and hospital learning priorities from analyses of both the quantitative (completed FY02-03) and qualitative assessment (to be completed in FY 03-04) data, use the criteria to review existing learning products produced by academic institutions and others.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	Focus Area G Coordinator RLS

▪ Work with the NCCPHP and HHS Region 10 to identify stakeholder groups investigating web conferencing services. ▪ Collaborate with these stakeholder groups to test possible solutions, compare notes on functionality. ▪ Recommend a solution.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	Focus Area G Coordinator NWCPHP HHS Region 10

Evaluation Metric:

1. Number of scholars from Washington State
2. Dissemination of lessons learned from Top-off2 to local health and other stakeholders and number of participants
3. Criteria established for review and number of learning products evaluated Web conferencing solution recommended
4. Certificate received for PH Ready

Strategy 6: Learning Technology Improvements

Local Capacity:
Analyze results of assessments completed by local public health agencies and hospitals in 2003 to identify priority areas for funding technology improvements.

State Capacity:

- Equip DOH EOC facility in Olympia with computers to use for training and EOC functions
- Equip DOH Olympia site with satellite dish so that DOH professionals can more easily access training and to provide a redundant communication mechanism for EOC purposes

Tasks	Timelines	Responsible Party
Local Capacity Complete analysis of capacity assessment results from 2003 Identify, and prioritize necessary improvements for individual organizations and facilities. (e.g. increased videoconferencing capacity for selected **hospitals** and Local health jurisdictions) For identified priorities, develop the requirements to meet DOH/LHJ/hospital business needs and recommended technical implementation plan. (Including clarifying ongoing maintenance and support costs, technical infrastructure requirements, purchasing and billing options) Recommend options for improvements	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	o Focus Area G Coordinator o Learning Technology Specialist o DOH DIRM o Contractor o Hospital Learning Liaison
State Capacity Determine roles and responsibilities for purchase, installation and ongoing technical support and maintenance; computers, satellite dish, videoconferencing equipment or other technology investments for each region Determine technical, purchasing and installation requirements for computers and satellite dish at the DOH EOC facility.	Please see Appendix E, "HBPP FY 03 Workplan Timelines".	o Focus Area G Coordinator o Learning Technology Specialist o DOH DIRM

Evaluation Metric:

- Assessment results analyzed.
- Percentage of organizations needing learning technology improvements that have made improvements.
- Number of participants using technology for learning

HRSA Priority Area # 6: Terrorism Preparedness Exercises

Summary:

Currently, Washington State's hospitals are completing their bioterrorism response plans. These plans are being coordinated with local and regional public health response plans in order to ensure a fully integrated approach to responding to an act of bioterrorism or other public health emergency. During the grant period, each local and regional public

health jurisdiction will be conducting a tabletop, functional, or full-scale exercise to test and validate their plans. Hospitals will be key players in each of these exercises.

Washington State will also conduct a large-scale regional bioterrorism exercise that will test all major components of the public health and medical emergency response system. Players will include, among others, state, regional, and local public health, emergency management, and pre-hospital systems, as well as hospitals. Also invited to participate will be the tribes, Red Cross, and Federal government (including the Dept of Homeland Security, CDC, HHS). As the geography region selected for this exercise permits, we will invite neighboring states and/or Canada to participate.

These exercises will be evaluated through a series of after action reviews. Results will be documented and used to identify deficiencies in existing plans as well as to identify areas where training needs to be strengthened.

Critical Benchmark #6:

As part of a written evaluation of the awardee's program, conduct at least one bioterrorism disaster exercise in the jurisdiction in FY 2003 that covers a large-scale epidemic scenario affecting both adults and children.

Strategies: What overarching approach (es) will be used to undertake this activity?

The State Department of Health and each regional and local health jurisdiction, with the players listed above, will conduct a tabletop, functional or full-scale exercise of their plans during the grant period to demonstrate proficiency and preparedness in responding to bioterrorism, other infectious disease outbreaks, or other public health threats and emergencies. Testing of the approved regional hospital plans will be an integral component of these exercises. Additionally, in conjunction with its local partners, including hospitals, the State will conduct a major regional, full-scale bioterrorism exercise testing all major components of the public health and medical emergency response system.

Tasks: What key tasks will be conducted in carrying out each identified strategy?

1. Each local health jurisdiction will conduct a tabletop or functional exercise of their plan during the grant period. Exercise results will be used to validate and update each plan.
2. Each regional health jurisdiction will conduct a tabletop or functional exercise of their plan during the grant period. Exercise results will be used to validate and update each regional plan.
3. A full-scale bioterrorism exercise will be conducted involving State, regional, and

local public health organizations and hospitals to validate our plans and determine our level of preparedness. The federal government, affected Indian tribes, and as appropriate neighboring states and Canada will be invited to participate. The exercise scenario will include deployment of the Strategic National Stockpile.

Timeline: What are the critical milestones and completion dates for each task?

Please see Appendix E, "HBPP FY 03 Workplan Timelines".

Responsible Parties: Identify the person(s) and/or entity assigned to complete each task.

1. Thirty four local health jurisdictions across the state
2. Nine regional health jurisdictions
3. Washington State Dept of Health (overall coordination) local and regional EMSTCCs, hospitals, community health centers, tribal public health and homeland security agencies

Evaluation Metric: How will the agency determine progress toward Washington State successful completion of the overall recipient activity?

1. Exercise all local plans and validate and update based on exercise results
2. Exercise all regional plans and validate and update based on exercise results
3. Completion of exercise and utilization of lessons learned to identify areas needing improvement and update of emergency response plans.